Kansas Medical Assistance Program SIA Application: Step-by-step guide

Go to www.kmap-state-ks.us Click: Start new application

Click START, or Resume application
Enrollment Pre-Checklist

Enrollment Type: Facility; Provider Type: Hospital; Specialty: 019- State Mental Hospital

NOTE: The Enrollment Type and Provider Type are not changeable. If you choose the wrong type for either, the application will not be usable, and you will need to start a new application.

Effective date can be back dated if needed.

Are you Medicare enrolled: Yes (if you click No- it will not allow you to more forward at #7)

Tax ID Type: EIN; I will accept patients in the following programs: FFS and MCO; Click: Generate Pre-checklist

See below for the information and documents that you will be required to provide to complete your application. Have them ready to move on.
Start application, it will ask you to register your account.

Provide your email and create a password. If you are enrolling more than one location – fill out the provider reference box. It will allow you to distinguish between the multiple applications you are submitting.
Click on KMAP Provider Enrollment Wizard or Start New Application

The next page will have a bar at the top of the page with 13 steps you will need to complete; it will show your progress through the application:
#1 General Information. It is important to choose correct options – after moving past page 1 you will not be able to change the Enrollment Type or Provider Type.

Enrollment Type: Facility

Provider Type: Hospital

Specialty: 019 - State Mental Hospital

Choose the date you want to be active (the date you are filling out the application) and it can be backdated as well.

Once you click save and continue on the previous page, you will receive an email with the tracking number.
Congratulations! You have successfully registered for your provider enrollment application with the Kansas Medical Assistance Program. Below is your tracking number that has been associated with your enrollment application. If you have not submitted your application, it will remain valid for 30 days from the last time you updated it.

Tracking Number: 0719592566
Password: $******
Provider Reference: Test Demo

To resume your partially completed enrollment, simply access the site at the address below and enter your enrollment tracking number and the password you entered during the registration process.

https://portal.kmap.state.ks.us/ProviderEnrollment/EnrollmentResume/

If you have any questions or concerns, please contact Provider Enrollment at your earliest convenience.

Sincerely,

Kansas Medical Assistance Program
Provider Enrollment
Kansas-Provider-Enrollment@dx.com
Contact us: 1-800-933-9593

Fill out your Provider Information
You will need to select Yes for the “Are you Medicare enrolled?” question, or you will not be able to get past # 7 in the application as it will require you to provide your Medicare number.

Select FFC and MCO

Select MCOs you would like to select. You can select 1, 2 or all 3

Select no for CAQH question
Provide Contact Information

Email is required even though there is no asterisk. Email is always a preferred method of communication.

#2 Specialties. Create New. Select 019- State Mental Hospital and make it Primary.
### Taxonomy - Hospitals/Psychiatric hospital

The provider type selected on the previous page determines the specialties available. One specialty must be named as primary.

#### Provider Type
- Hospital

#### Specialty Taxonomy Waiver/Entitlement Type Primary Effective Date Edit

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Taxonomy</th>
<th>Waiver/Entitlement Type</th>
<th>Primary</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>018-State Mental Hospital</td>
<td>2812000000X-Hospitals/Psychiatric Hospital</td>
<td>x</td>
<td>02/12/2021</td>
<td></td>
</tr>
</tbody>
</table>
To add more taxonomies- click edit. For SIA enrollment – you will need one only

Save and Continue

Step #3 Service Location. Create new
Provide details; Save and Continue
To add a phone number - click Create new and add a phone number, save and select hours of operation, create new and select the hours, click Save.
Step #4 Addresses. Click Same as Service Location to autofill or provide other details manually.
Information below is Optional: Informational Mail Address; Remit TO; Doing Business as; Medical Records Request
# 5 Organizational Details.

If your business is chain affiliated, the information about the company or organization must be included in the disclosure information.

If your business is operated by a management company or leased (in whole or in part) by another organization, information about the management company or organization must be included in the disclosure information.

Next part is optional:

#6 Associations — Will be left blank
#7 Credentials. For instate Kansas providers- leave blank or it will ask you to fill out details. IF you accidentally click new one- use dummy info

MEDICARE Participation is required
If you are not participating in another State Medicaid program- select No

Leave CLIA information blank

Bed information: create new.

For psych hospitals only – only choose psych beds
# 9 Languages, Certification, Additional info and malpractice information

### Additional Information

Please enter the provider website address below. It must begin with “http” or “https” followed by a valid address.

Provider Website URL: 

### Malpractice Information

Please complete the malpractice information below.

<table>
<thead>
<tr>
<th>Type of Carrier</th>
<th>Name of Carrier</th>
<th>Coverage Amount Ag</th>
<th>Coverage Amount Per Person</th>
<th>Policy Number</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Edit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Liability</td>
<td>Blue Cross</td>
<td>10000</td>
<td>10000</td>
<td>111111111111</td>
<td>6/21/2021</td>
<td>6/30/2021</td>
<td></td>
</tr>
</tbody>
</table>

Are you currently or have you within the last ten years been involved in a malpractice suit or claim in which your care and treatment of a patient was at issue, including pending or dismissed cases or claims settled before or during trial or settled to avoid a lawsuit? 

[ ] Yes  [ ] No

# 10 Disclosures. Fill out each of the following by clicking Create NEW: Provider Self Disclosure; Sub-Contractor Disclosure; Ownership and Control Interest; Managing employees; Business Transaction
**Disclosure Forms**

<table>
<thead>
<tr>
<th>Disclosure Form</th>
<th>Status</th>
<th>Create New</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Self Disclosure</td>
<td>Completed</td>
<td>CREATE NEW</td>
</tr>
<tr>
<td>Sub-Contractor Disclosure</td>
<td>Completed</td>
<td>CREATE NEW</td>
</tr>
<tr>
<td>Ownership and Control Interest</td>
<td>Completed</td>
<td>CREATE NEW</td>
</tr>
<tr>
<td>Managing Employees</td>
<td>Completed</td>
<td>CREATE NEW</td>
</tr>
<tr>
<td>Business Transaction</td>
<td>Completed</td>
<td>CREATE NEW</td>
</tr>
</tbody>
</table>

---

**New Provider Self Disclosure**

**General**

- **Is the provider part of a provider or entity that is subject to the provisions contained in Section 6032 of the Deficit Reduction Act?**
  - Yes
  - No

- **Provide the following information for the contact person for audit purposes.**

  **Title**
  - [ ]

  **Last Name**
  - Green

  **First Name**
  - Gregory

  **Address Line 1**
  - 6511 SE Forbes Ave

  **City**
  - Topeka

  **State**
  - Kansas

  **Country**
  - United States

  **ZIP Code**
  - 651-

  **Phone Type**
  - [ ]

  **Phone Number**
  - [ ]

  **Address Line 2**
  - [ ]

  **City**
  - [ ]

  **State**
  - [ ]

  **Country**
  - [ ]

  **ZIP Code**
  - [ ]

---

**REFERENCES:**

- Federal law requires individuals and entities with ownership, control, management, or a business relationship to submit a separate disclosure form for each entity or person affiliated with the provider. For more information on federal disclosure requirements, see 42 CFR § 455.100 – 196, 42 CFR § 455.436, 42 CFR § 1002.3, and CFR § 438.002 (b).

---

**SEARCH:**

- [ ]

---

**19**
# 11 Attachments

Upload the documents by going to Details, Create New, transition Method, Attachment. Make sure all the Requirement Met box say: YES

#12 Application Fees.

As of 6/22/2021 the fees are waved due to COVID, but fees are going back into effect.
Click Proceed

Click YES to agree
Accept, sign and Request Verification code

You will receive an email

Plug in the code form the email and Submit the application.

Congratulations! Your application has been submitted. Please let KDADS know that the application has been submitted, provide the MCOs that you have selected along with the application #s.

THANK YOU